Welcome to our office! Please let us know if there is anything you need during your visit.

Patient Information

Today's Date: ______________________________

Last Name: ________________________________

First Name: ______________________ MI: ______

Gender: M F Date of Birth: ________________

Address: __________________________________

City: ___________________ St:____ Zip: _______

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone:_______________________________

E-mail Address: ___________________________

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Race: _____________ Ethnicity: _____________

Would you like text reminders for appointments? Y N

What is your preferred method of communication?

___Mail ___Telephone ___E-mail

Marital Status: ____________________________

Employer: _________________________________
Occupation: _______________________________

Emergency Contact: _______________________

Phone:_________________ Relation:__________

INSURANCE INFORMATION

Medical / Vision / Both
Policy Holder's Name:__________________
Policy Holder's DOB: ____________________
Policy Holder's SSN: ____________________
Relation to Patient:______________________
Patient's SSN: ________________________

Lifestyle Questions

Are you planning on purchasing glasses today?	**Yes No**
Do you have prescription sunglasses?	**Yes No**
Do you spend a lot of time on a computer?	**Yes No**
Are you interested in contacts?	**Yes No**
Do you suffer from dry eye symptoms, such as Grittiness, scratchiness, burning, or watering?	**Yes No**

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Louisiana Family Eyecare's (LAFE) statement on privacy practices.

☐ Do not share my health information with anyone.
☐ It is ok to share my health information with family.
Family Members_________________________________

INSURANCE AUTHORIZATION: I hereby authorize LAFE to release any information to insurance carriers necessary to obtain payment. I assign LAFE benefits for services rendered today and in the future. I understand that I am responsible at time of service for any amount not covered by insurance (e.g. deductible, co-payments, and denials).

FINANCIAL POLICY: I have read and understand the financial policies of LAFE.

CONSENT FOR TREATMENT: I hereby authorize LAFE to administer diagnostic and medical procedures as necessary for proper health care.

Signature: ______________________________

Retinal Exam Informed Consent

We recommend one of the following options annually for early detection of eye diseases.

Option 1: OPTOMAP
We are committed to providing the highest level of care by using the most advanced diagnostic tools to ensure a comfortable and efficient exam. Optomap is a scanning laser imaging system that is able to capture 80% of the retina WITHOUT being dilated. The fee for this is $35 and is not covered by insurance.

Option 2: Dilated Retinal Exam
With dilation, drops are placed in the eyes to enlarge the pupils so that the doctor can carefully examine your retinas. You will be sensitive to light and have blurry near vision for 3 to 6 hours. Driving is generally possible, however caution should be exercised.

I have read and understand the options

☐ Yes, I give consent for Optomap today for $35.

☐ Yes, I give consent for dilation today.